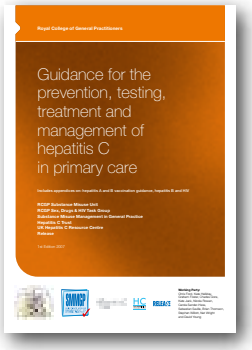
network
NETWORK 18 JULY 2007

Hepatitis C Guidance Launched

Guidance for the prevention, testing, treatment and management of Hepatitis C in Primary Care



The following is a summarised excerpt from the recently produced *Guidance for the prevention, testing, treatment and management of Hepatitis C in Primary Care.* **RCGP SMU and Sex, Drugs & HIV Task Group, SMMGP, Hepatitis C Trust, UK Hepatitis C Resource Centre & Release. Ed**

The full guidance and others in the series are available online at www.smmgp.org.uk and www.recgp.org.uk.

This guidance has been produced to aid medical practitioners and others in the management of hepatitis C infection in Primary Care. Hepatitis C virus (HCV) was first identified in 1989 and rapidly emerged as a significant world public health problem.[1] Every general practitioner is likely to have between 8 to 18 infected individuals, with an average list size of 1,800, partly depending on local population demographics. However, many of these patients may go undiagnosed. In a majority of people hepatitis C is a curable disease and therapy is recommended by the National Institute for Clinical Excellence.[2,3]. However treatment rates in the UK remain low despite the on-going patient awareness campaigns, NICE recommendations and pressure from informed clinicians and their patients. Diagnosed individuals in France are 6 to 12 times more likely to enter treatment programmes.[4] It seems the lack of awareness in primary care contributes to the low treatment rates in the UK and the purpose of this guidance is to provide clinical information about the management of hepatitis C infection in primary care that, hopefully, will lead to increased prevention of HCV transmission along with improved testing, diagnosis and treatment for patients who are already infected. It has been shown that general practice has an important role in the care of people at risk of hepatitis C and when appropriately supported can effectively implement current best practice.[5]

...continued on page 10

Snowballing: Combined Heroin and Crack Injection

Danny Morris and Claire Robbins take us through the basics of snowballing, the injecting of heroin and crack cocaine together, a form of drug use that is increasing in the UK. They highlight the complexity of harms associated with the practice, and the need for a broad range of harm reduction interventions when working with people who are snowballing. Ed

...continued overleaf

In this issue

We hope you enjoy this issue.

Editor

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

Editorial

It was great seeing so many of you at the National Conference in the Management of Drug Users in Primary Care at the end of April. Many of the presentations from the conference are available at www.smmgp.org in the resource library section, and our consensus statement and a brief overview is on page 7. We can announce that the conference is to be in Brighton in 2008, on the 24th and 25th April, with other hosting offers made for 2009, 2010 and 2011! So, a date for your diaries.

SMMGP would like to announce that Kate Halliday will be taking on the role of Network Editor as I will be emigrating for a couple of years. For now, I would like to thank everyone who has worked with me and been kind enough to send in articles and support the newsletter.

Jean-Claude Barjolin

Kate Halliday writes a few words as editorial

I am delighted to be taking on this role and am looking forward to being so closely involved with my favourite newsletter! Jean-Claude started working on Network over 10 years ago and has helped build it into one of the most established, high quality clinical newsletters in the UK drug field- I hope that I can live up to the high standards he has set. I am sure I am not alone in wishing him good luck on his travels.

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Background

Speedballing is a term used to describe the injection of heroin combined with powder cocaine and originates in the USA. Drug agencies and researchers in the UK have seen an increase in the combination of heroin and crack as an injection, more commonly called Snowballing.

Generally to prepare a snowball, heroin is cooked with citric first, and then crack is crushed, added to the solution, filtered and loaded into the syringe. However there are varying reports of methods of preparation some of which could readily lead to extensive levels of tissue damage and elevated rates of BBV transmission.

Although the combined use of cocaine and heroin has been reported since 1990's this is not a new phenomenon by any means; however it has been growing at an alarming rate amongst often the most vulnerable group of drug injectors with poor coping skills and unsettled lifestyles.

Frequently drug services feel less well equipped to support, manage and provide appropriate responses to those injecting crack and heroin and many feel deskilled in dealing with the growing phenomenon.

Prevalence

At the Soho Rapid Access Clinic (SRAC) working with homeless drug users, rates of snowballing accompanied by polydrug use (alcohol, benzodiazepines and methadone) are as high as 66% on referral. As NDTMS does not collate reporting of combined use as a 'primary drug' we believe that under reporting is a feature in many areas. A report published in the International Journal of Drug Policy described the increase in crack injection, with 40% of users combining crack with heroin in the past month. These rates climbed as high as 70% in some areas [1].

Pharmacology and neural pathways

The pharmacology and neurobiology of combined use is poorly understood [2]. Although it is known that opoids and cocaine have different mechanisms of action both drugs share important characteristics and serve as powerful motivators of repetitive behaviour. There is considerable evidence that common reinforcing and incentive effects of these drugs are mediated by increasing dopamine levels [3].

Opiates modifiy the action of dopamine in the nucleus accumbens and the ventral tegemental area of the brain that forms part of the brains reward pathway. After administration by injection, heroin, transported in the circulatory system readily crosses the blood-brain barrier when it is converted to morphine. Morphine acts as an agonist at the delta, kappa and mu opioid receptors. This binding inhibits the release of GABA, an inhibitory neurotransmitter, from the nerve terminal, resulting in a reducing of the inhibitory effect of GABA on dopamine production. The resultant increase of dopamine flooding into into the synaptic cleft results in activation of the post-synaptic membrane leading to the feelings of euphoria and the high associated with heroin use.

Cocaine also modifies the action of dopamine in the brain but through very different mechanisms. After administration cocaine binds to dopamine re-uptake transporters on the pre-synaptic membranes of dopaminergic neurones. This binding inhibits the removal of dopamine from the synaptic cleft and its subsequent degradation in the nerve terminal. Consequently dopamine remains in the synaptic cleft and is free to bind to its receptors on the post synaptic membrane. The resultant increased activation produces further nerve impulses and it is this increased activation that leads to the feelings of euphoria and the high associated with cocaine use.

From this simplified description of opiate and cocaine mechanisms of action it can readily be seen that combined use, through different actions, causes a net and dramatic increase in dopamine levels. These processes may account for the effects described by snowballers. Certainly reports from those injecting heroin and cocaine in combination that suggest a qualitively enhanced and more pleasurable experience than when either drug is taken in isolation.

Studies looking at the possible neurobiological interactions between opiates and cocaine have been difficult to interpret, however, because of the

complex nature of the neurobiological mechanisms. These are altered by varying factors such as repeated use, increased or fluctuating tolerance, duration of drug use and withdrawal.

Indeed, clinical and pre clinical experimental evidence, contrary to consistant user reports, indicates that snowballing does not induce a novel set of subjective effects nor is it more reinforcing than either drug alone [2].

Evidence from the street

Injecting drug users commonly explain their use as possibly being led by availability of heroin and crack via the same markets. When both drugs are sold together, they are more likely to be used in combination. The buying of 'brown & white' would appear to be increasingly common. Others will say that it "feels better", and many have become bored with heroin alone, and are finding that the combination gives them an experience more akin to their early using days. This maybe related to a reduction in drug quality.

There are also reports of financial incentives to buy both drugs. When talking with service users, we hear of the market selling both drugs together, and deals being offered. Sold separately two items cost £20, however if bought together, £15. The additional costs of snowballing encourages people to pool their resources to buy and then prepare drugs for injection. Shared drugs are invariably prepared in batches with indirect sharing of equipment being the norm.

Snowballing and crack injection has been noted to be within communities who have a higher prevalence of HIV and Hepatitis C [4]. In terms of equipment, 24% report sharing needles, and 55% report sharing other equipment [5]. In addition to this, injectors are reporting veins collapsing quickly, with reports of many missed hits masked by the local anaesthetic properties of cocaine and vasoconstriction. The readiness with which superficial veins become unusable is often cited as a rational for femoral injecting.

The frequency of snowballing injection can be high, with some users reporting injecting as many as eight times a day. Couple this with a homeless lifestyle and limited access to washing facilities, and you have a breeding ground for infection. As veins collapse quickly, there is an increased association with femoral injection, as a "sure shot". This in turn carries its own risks and problems, with DVTs and leg ulcers developing. In addition to physical health problems, snowballers tend to have poor treatment outcomes, unstable accommodation, increased homelessness and limited support [1].There are higher levels of dual diagnosis within this group and all of these components combine to provide a challenge to services [6].

Indicators for enhanced treatment

Traditionally drug treatment services in the UK have been opiate focused, and have had the additional help of pharmacological interventions such as methadone and buprenorphine. With crack and cocaine, progress has been slow in determining a pharmacological response to this increasing trend in drug use.

There is a need for integrated services around both mental and physical health, along with increased provision of comprehensive needle exchange and services such as HIV and Hepatitis testing and vaccination. Service users themselves express a need for harm reduction information and education to be provided. Many are unaware of the increasing involvement of crack and cocaine in drug related deaths. There is a need to educate workers who come into contact with this group, so that both workers and service users can deal confidently with problems associated with snowballing.

Based on the evidence discussed there is a requirement for a broad range of harm reduction interventions to encompass the complexity of the harms associated with snowballing. In addition to offering essential safer injecting advice, services should provide reverse transition interventions to support smoking as an alternative to injecting where practicable. Overdose education should incorporate snowballing as an elevated risk to users. There is also a need for further development of safer injection interventions based on research into street drug preparation and use to determine to what degree combined use might be made safer.

References

1 **Rhodes T et al. International Journal of Drug Policy. June 2006(vol 17, Issue 3, pages 164-170)**

2 **Francesco Leri; Julie Bruneau; Jane Stewart. Understanding polydrug use: review of heroin and cocaine co-use 2003 Society for the Study of Addiction to Alcohol and Other Drugs, Addiction 98, 7-22)**

3 **Jennifer L Cornish; Jaclyn M Lontos; Kelly J Clemens; Iain S McGregor. *Cocaine and Heroin ('speedball') self –administration: the involvement of nucleus accumbens dopamine and mu opiate but not delta opiate receptors* Published online: 29 Jan 2005 Psychopharmacology (2005) 180: 21-32)**

4 **Shooting Up, Health Protection Agency.2006**

5 **Ali Judd et al Incidence of hepatits C virus and HIV among new injecting drug users in London:- prospective cohort study. BMJ; 2005; 330; 24-25**

6 **C Amalia Marrero et al Factors associated with drug treatment dropout among injection drug users in Puerto Rico. Addicitive Behaviours 30 (2005) 397-402)**

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The Adelaide Street NES

Michael Taylor tells the refreshing story of how he managed to realise his dream of providing high quality care for drug using patients in his practice. He has done this purely based on NES monies which have been invested in staffing for the scheme (they don't actually cover his time as yet). He also tells the story of how, in investigating the unfortunate death of a patient in the scheme who had discharged herself from hospital, they uncovered worrying results in terms of drug using patient's experience of hospital treatment. A true tale of proactive development of services, robust responses to critical incidents and forward planning. Ed.

I could get addicted to the feeling. You know the one where for years you have pushed and heaved against the unyielding wooden door marked "Future" when suddenly with the merest touch it swings wide open.

For ten years I had tried to get financial help to provide some sort of service for those of my patients with problems of addiction. I reckoned that my small practice of 3000 patients had 65 patients addicted to class A drugs and a similar number addicted to alcohol. My campaign slogan had been "another time, another place." Matters came to a head in 2004 when I had three almost identical complaints from patients; these were about my failure to curb the behaviour of other patients in the waiting room. This was a bit of an eye opener in itself as I had never considered that other people's behaviour was my responsibility! Needless to say the behaviour to which my patients referred was disinhibited behaviour fuelled by drugs or alcohol or both.

Then along came the New Contract for GPs with the promise of a National Enhanced Service for drug misuse to breathe new hope into our uncomfortable situation. This was the first of three pieces of good fortune.

The second was that the surgery premises had some additional space. Well it did and it didn't for the space that was not being used for practice purposes was used by a small educational section of the Primary Care Trust. With the practice premises being built on a slight hill there is street level access on two floors with what is the basement from one side being the entrance from the other. The small education unit was housed in what we termed the lower ground floor. I took my courage in both hands, served a notice of eviction of the PCT staff and held my breath.

The reception desk at Adelaide Street

To my relief the educationalists evicted were delighted as they could seek better premises. No murmur of surprise or antipathy reached my ears from the PCTs Director of Finance. So we now had space.

The third piece of good fortune was the human one. I had a member of my administrative staff who was underemployed, enjoyed making order out of chaos, and was as unflappable and smooth tongued as a latter day Sybil Fawlty. Seated at her desk in the patient waiting area of the NES, warm hearted, kindly, Ann has become the epicentre of all that has subsequently been achieved.

We produced a plan, circulated this to the PCT, and the Drugs and Alcohol Action Team, both of whom were supportive. So we were in start-up.

Like any good business we had to plan our future financially. 65 patients at just more than £400 a head would not cover start up and revenue costs especially as we managed to obtain the services of a part time male practice nurse. We had to gamble a little in that we could make a service attractive to drug users in the town who did not attend the Community Drugs Team (CDT). This we achieved by securing services from other agencies to be delivered on site and by establishing an ethos of service which fitted with the accelerated and chaotic lifestyle of most of those addicted. We calculated break even at 120 patients and at about 180 the service would not only break even

and but be able to pay me for my time, currently a session and a half a week.

But, as Burns would have it, "the best laid plans gang oft agley." We, by this I mean the core NES team, were three months in to our first year of operation when we were stunned by the unexpected death of a 24 year old young woman I shall refer to as Susan. She had died in the shadow of a General Hospital in the nearby town of Oldham. Susan had until two days prior to her death been in the hospital from which she self discharged, subsequently dying alone in her own flat. A Coroner's inquest was inevitable. Our primary concern was of course for her and her parents, but our sorrow was tinged with anxiety that we had contributed in some way to her premature death.

As a practice we have for a good few years used the tool of significant event analysis to tease out points for learning and change; Susan's death was not to be an exception. The practice area is about one mile in radius and Susan had gone to live abut 6 miles distant; was this distance a contributing factor? Our Significant Event Analysis (SEA) concluded not; we thought that Susan's self discharge was the single important factor in her death. But of course this begs answer to the question, why a 24 year old would discharge herself from hospital to die tragically from something as simple and treatable as bronchopneumonia.

As a mark of respect to Susan we determined to find out more. We prevailed upon the good nature of the post grad centre's librarian to perform two searches for us; one on attitudes of secondary care staff to patients with problems of addiction and the other attitudes of drug users to hospitals and the staff. The papers retrieved about staff attitudes can be summed up with the charitable phrase, "at best, mixed." The latter search yielded but one small paper from Northern Ireland. So with her parents' permission, we designed a questionnaire to explore the attitudes of our NES patients towards hospital care.

The questionnaire was administered with surprising difficulty to 50 patients of the NES. The questionnaire took about 15 – 20 minutes to complete; help was offered. All who were asked expressed willingness to help with the survey, but such help was frequently postponed. We had of course in our naivety stumbled upon that paradox of psychomotor acceleration; "nothing to do but in the helluva hurry to get there to do it." To complete 50 questionnaires took two months but I think was worth it. The results stated briefly are:

- One third of N.E.S. patients indicated that they were unlikely to accept the G.P., nurse or drug worker's recommendation for admission to hospital.
- Half of these patients remembered they had been advised to go to hospital in the past 5 years.
- Two thirds of these patients had been an in-patient on at least one occasion in the past 5 years.
- Of those who were in-patients, half had taken their own discharge.
- The main reason stated for self discharge were:
  - Attitudes of the nursing and other staff
  - Waiting times to see a doctor on the ward
  - That they did not receive maintenance medication
- Half of these patients while in hospital took 'street drugs'

If we ever get a moment we could and maybe should try to get the results presented by some peer referenced journal, so if you know someone who is involved with publishing deny that you read this here first!

I confess we felt a little chuffed having analysed our results and determined to present them to colleagues from the co-operating agencies at an away day, organized by the NES primarily to enhance team work. Despite the fact that our presentation was well received any reflective smugness was soon erased by our colleagues chomping at the bit to drive down the "road to recovery". By this I mean that maintenance and harm reduction, as practiced by the NES was thought to be the mere foothills of the distant mountains to be climbed, the twin peaks named Recovery and Abstinence.

So to conclude by looking back over 18 months at our achievements:.

We have 126 patients in active treatment so we have revenue breakeven. This number continues to slowly grow.

We practice harm reduction so some of our patients should be healthier that they otherwise might have been.

I think, but don't have the figures to prove, that the greatest benefit to the group as a whole has been the diminution of criminal activity and the legal consequences. I imagine that this will in turn have a positive benefit upon family life and relationships of our patients.

As for the NES team, well, by opening the door marked "Future" we appear to have vanquished one set of problems only to be confronted with another: but we confess to having had fun in doing it.

Michael Taylor GPwSI, York House Surgery, Heywood, Lancashire

Analysis of SMMGP Membership

Contingency Management Consultation

SMMGP recently conducted a consultation of its membership on contingency management. This approach, which involves the giving of financial rewards to patients in return for treatment compliance, has been recommended in the draft NICE psychosocial guideline and to a lesser extent in the draft NICE detoxification guideline. It has a robust evidence base, from the US and Australia but not as yet from within the UK. In the US it has been proven to be cost effective, but the drug treatment system is very different there. Here it remains a matter of debate within the field. We felt that it would be of value to the field for the views of SMMGP members to be published. Here are the results:

Notes

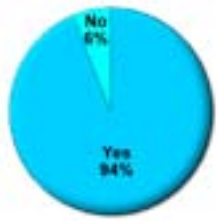
1. Total number of responses analysed 63.
2. Comments have been collated into groups, these are not respondents' actual words.
3. Only comment groups with 3 or more responses have been included.
4. Percentages have been included for comment groups over 10.
5. No comment groups were suggested to respondents (see questionnaire).
6. Job titles have been generalised (e.g. GPSI has been listed as GP).
7. Secondary analysis was done regarding GP responses as they were by far the largest group

Do you think contingency management will be of benefit to the drug treatment field?

Yes	31	(49%)
No	18	(29%)
Unsure	13	(21%)

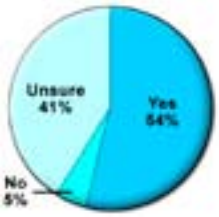
Can you see any obstacles to the implementation of contingency management?

Yes	59	(94%)
No	4	(6%)



In your opinion will contingency management be welcomed by patients?

Yes	34	(54%)
No	3	(5%)
Unsure	26	(41%)



Respondents were able to comment after all these questions but after analysis it has seemed more useful to just report all these comments as either positive, or highlighting potential problems/ negative responses.

Comments

Positive:

- Reinforces benefit of treatment (9)
- Will engage stimulant users (5)
- International evidence base (3)
- Seeing tangible reward (4)
- Positive rather than punitive (3)
- Effective motivational tool (3)
- Initially would be popular (4)

Potential problem/negative responses:

- 37 (59%) respondents said that there would be problems with monitoring and giving out rewards, especially with people trying to cheat the system and the organisational difficulties of implementing it.
- 27 (43%) felt there would be a backlash from the general public/media with some saying this would greatly damage the drug treatment filed.
- 21 (33%) had concerns about funding, how it would be paid for and what other services would suffer as a result
- Treats patients like children/disempowers/is patronising (11)
- Resentment if not seen as fair (7)
- Undermines open, honest patient-centred relationships and co-operation (7)
- People give up when ready (5)
- Bribery (5)

- Discriminatory against other chronic disease patients (6)
- Failure not always clients fault (3)
- We should be reinforcing other psychosocial options (3)
- Should be done on an individual basis (3)

Other Comments

- Needs to be tailored to the individual (5)
- Needs to be consistent across services and across the country (5)
- Needs to be piloted/trialed (4)

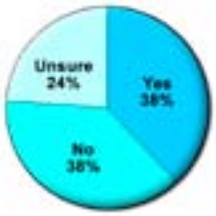
Job Titles

Nurse	10
DAT Officer	3
GP	29
Psychiatrist	2
DIP worker	1
Forensic physician	2
Service manager	2
Medical officer criminal justice	4
Shared care co-ordinator	5
Drug worker	1
Pharmacist	2
Service user	1
Not identified	2

Analysis of GPs only

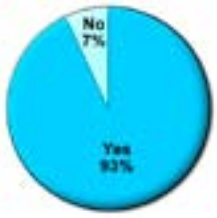
Do you think contingency management will be of benefit to the drug treatment field?

Yes	11	(38%)
No	11	(38%)
Unsure	7	(24%)



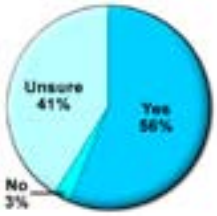
Can you see any obstacles to the implementation of contingency management?

Yes	27	(93%)
No	2	(7%)



In your opinion will contingency management be welcomed by patients

Yes	16	(56%)
No	1	(3%)
Unsure	12	(41%)



Comments

- 18 (62%) GPs said that there would be problems with monitoring and giving out rewards, especially with people trying to cheat the system and the organisational difficulties of implementing it.
- 13 (45%) felt there would be a backlash from the general public/media with some saying this would greatly damage the drug treatment filed.
- 8 had concerns about how this was to be funded
- 5 thought it was patronising
- 5 thought it was discriminatory against people with other conditions
- 3 thought it an effective motivational tool
- 3 said it had a robust evidence base
- 3 said it would be seen as punitive
- 3 said more research and/or piloting was needed

To read the full NICE guideline see
http://www.nice.org.uk/page.aspx?o=397260

Below is the main extract from the draft guideline:

Contingency management provides a system of incentives to change behaviour. The emphasis in contingency management is on offering incentives for behaviours such as abstinence or reduction in illicit drug use, and engagement or participation in health promoting interventions.

For example, incentives are provided when a service user submits a biological sample (for example, urine or oral fluid) that is negative for the specified drugs. For contingency management to be effective, healthcare professionals need to discuss with the service user which incentives are to be used so that they are perceived as genuinely reinforcing by those participating in the programme. Incentives need to be provided consistently, and as immediately as possible after submission of the sample. Limited increases in the value of incentives with successive periods of abstinence also appears to be effective.

A variety of incentives have proved effective in contingency management programmes including privileges (for example, take-home methadone doses), vouchers (which can be exchanged for goods or services of the service user's choice) and monetary incentives.

To read the full NICE guideline see
http://www.nice.org.uk/page.aspx?o=397260

It's Brighton for 2008!

RCGP Management of Drug Users in Primary Care (MDUPC) Conference 2008

Another successful MDUPC conference was held in Birmingham in April. Here is the consensus statement from the conference, and we are already planning for the next conference in Brighton! Ed

It was great seeing so many of you in Birmingham at the national MDUPC Conference at the end of April. We can announce that the conference is to be in Brighton and the South East in 2008, the first time we have been to the South East - on 24th and 25th April, so a date for your diaries. In true Olympic spirit, we already have hosting offers for 2009, 2010 and 2011. The need to forward planning has become an aspect of the growing success of the conference, as few venues are now large enough to hold the event. We would like to thank Newcastle, Bristol and the South West and Harrogate for offering to host the event in the next few years. We will be looking at available venues, general logistics and the need to represent differing parts of the UK. A sincere thank you to potential hosts as we know that this is a big commitment requiring lots of effort and heart.

2007 Birmingham feedback and evaluation forms suggest it was another very popular and successful event with a great atmosphere and a huge range of thought provoking and inspiring presentations and parallel sessions. Conference presentations are available at www.smmgp.org in the resource library section. Our consensus statement alongside gives a pretty strong flavour of the themes, direction and outcome of the conference. It no doubt also sets our direction for 2008.

RCGP Substance Misuse Conference Consensus Statement

Getting it Right in Practice: Collaboration not Competition
12th National Conference RCGP Conference: Management of Drug Users in Primary Care,Thursday 19th and Friday 20th April 2007, Birmingham

Person-centred care is the main value underpinning all that we do in Primary Care.

We believe that all individuals should be able to have access to appropriate and effective primary care based drug treatment and healthcare within a collaborative whole treatment system.

All appropriate care options should be available wherever people are in the system and to all; on an unprejudiced basis, respecting diversity of human identity and experience. This can only be achieved in collaboration, and not in competition, with the whole community and its diverse elements including social, criminal justice and health.

Prisons and secure environments are part of our communities and *equivalence of opportunity* (matched by resources and policy) must be available to allow unprejudiced access to healthcare and drug treatment.

We respect the impact that monitoring and 'standardisation' has had on improving quality, however this should not become an end in itself. Practitioners need support and medico-legal backing to use their experience, judgement and clinical scope to work flexibly with individuals. Additionally, pressures for quantity of intervention and expedient outcome measures must not lead to a dilution of quality.

We call in particular on the media, and other sectors including Government, GP and other practitioner colleagues, to develop a responsible and mature code of conduct in relation to the reporting, discussing and addressing of drug issues: to help promote a greater societal responsibility which acknowledges and respond to, rather than scapegoats, the vulnerability, disadvantaged status and genuine harm experienced by many members of our communities.

We call on the Government to hear the voice of primary care, as a significant and progressive treatment community, in relation to the development of drug policy.

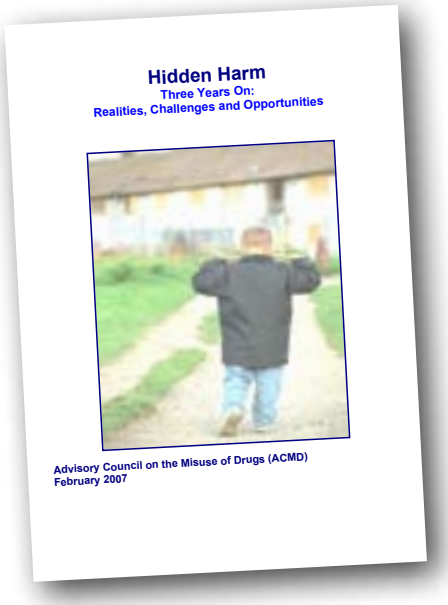
Jean-Claude Barjolin reports on the results of the SMMGP Network reader survey, which produced some positive feedback and good suggestions for future Newsletter articles. Ed.

SMMGP Network Reader Survey

Thank you to all who completed the reader survey. We had 205 responses with some really useful feedback, suggestions and offers for articles. As a flavour of the results, 95% of readers found it good or excellent with a mean score of 4.5 (with 5 as excellent), 93% found it good or excellent on presentation with a mean score of 4.3 (with 5 as excellent), and 98% found it the right balance between clinical, policy and research. You can see the full survey response at www.smmgp.org, News and Events section. We have an author in this issue who volunteered through the survey, Nicolas Smith and several more arranged for future issues. Thank you to all for the effort, offers and suggestions.

Jean-Claude Barjolin
SMMGP Network Coordinator

Hidden Harm 4 years on



Vivienne Evans, Chief Executive of Adfam, brings us up to date on the needs of children of problem drug users, and the impact of Hidden Harm four years on. We learnt that not all problem drug using parents are bad parents, we now see that agencies have begun to improve services, and responses to pregnant drug users have improved. However, we must not forget the complexity of working with dependency and parenting, improve at working with the family as a whole and still address issues of child protection. A much needed reminder on an important and sensitive topic. Ed.

In 2003, the Advisory Council on the Misuse of Drugs (ACMD) published its Report, 'Hidden Harm' – responding to the needs of children of problem drug users . This revealed a disturbing picture about the nature and extent of actual and potential harm to babies and children born to and living with parental drug misuse, and the inadequate response in the UK to this problem. The 48 recommendations cut across the drugs, children's, health and criminal justice sectors, and addressed a broad range of issues. They include joint working, research, identifying and recording needs, staff training, dedicated provision and protection for children affected. 'Hidden Harm' was welcomed by many practitioners as a validation of their work to champion the needs of the children of problem drug users and a wake up call to those who had neglected these needs in the past. 'Hidden Harm' documented the extent and complexity of the 'harms' experienced by the children of problem drug users and outlined the challenges that this presents in developing holistic responses to the needs of these children and their families.

The report focused on the impact of problematic drug use on children, strongly making the point that not all drug users are bad parents. Although the impact of problem drinking on children was not covered, there is now an acknowledgment that children living in families where any substance misuse is problematic, can experience fractured lives.

In 2004, a Working Group was established to monitor and promote the implementation of the recommendations of Hidden Harm. The Working Groups' report, 'Hidden Harm - Three Years On: Realities, Challenges and Opportunities', was published in February 2007 and is available on www.drugs.gov.uk

This report demonstrates that the original Hidden Harm report has had a significant impact on policy and practice at national, regional and local level. This impact is not yet consistent across all the UK and all 48 recommendations, but there is evidence of positive progress. The potential and actual harmful experiences of these children are becoming more widely acknowledged, resulting in more action by more agencies in more areas. Many useful practice examples and lessons from research and evaluation are identified within the report which demonstrates the positive impact of direct help and intervention for children and young people.

The report explains how children can experience improvements in their lives and those of their families, when responses are co-ordinated between and across adults' and children's services. This remains a challenge for some drugs services and social services. Consistent and comprehensive practice responses to children and their families are more likely to occur where multi-agency arrangements are in place, supported by agreed joint protocols and procedures. The report underlines the need for a comprehensive range of dedicated services at local level to respond to the needs of the children of problem drug and alcohol users. These services include specialist posts, dedicated provision for children affected which focuses on resilience, work with parents including drug treatment and improving parenting skills, plus joint work with the whole family

The report calls for adult drug treatment services to understand the complex relationship between drug dependency and parenthood. For most practitioners the primary responsibility is to treat the drug user as an individual patient. However, users are also parents, and responses need to be developed to reflect this. Interventions which engage the family as a whole, in order to develop resilience rather than combat risk, are increasingly recognised as the way forward.

The importance of child protection is highlighted within the report and it calls for the inclusion of a specific objective to safeguard and promote the welfare and protection of children of problem drug (and alcohol) users within the new drugs (and alcohol) strategies in England.

It is gratifying to note that responses to pregnant drug users identified in the original Hidden Harm report have been sustained. It demonstrates that where good practice guidance is available it can greatly assist managers and practitioners to put in place robust arrangements to identify and take appropriate action.

Responding to the needs of these children is every professional's responsibility, but practitioners need to be equipped to do this. The report calls for large-scale training and workforce development. The work of STRADA, a national training initiative in Scotland gives some sense of the scale of this challenge, but also the possibilities this approach offers.

Overall, there has been significant progress in responding to the needs of this particularly vulnerable group of children. Harm is becoming less hidden, but in the spirit of all reports, it stresses that there is still more to be done. We could still do better!

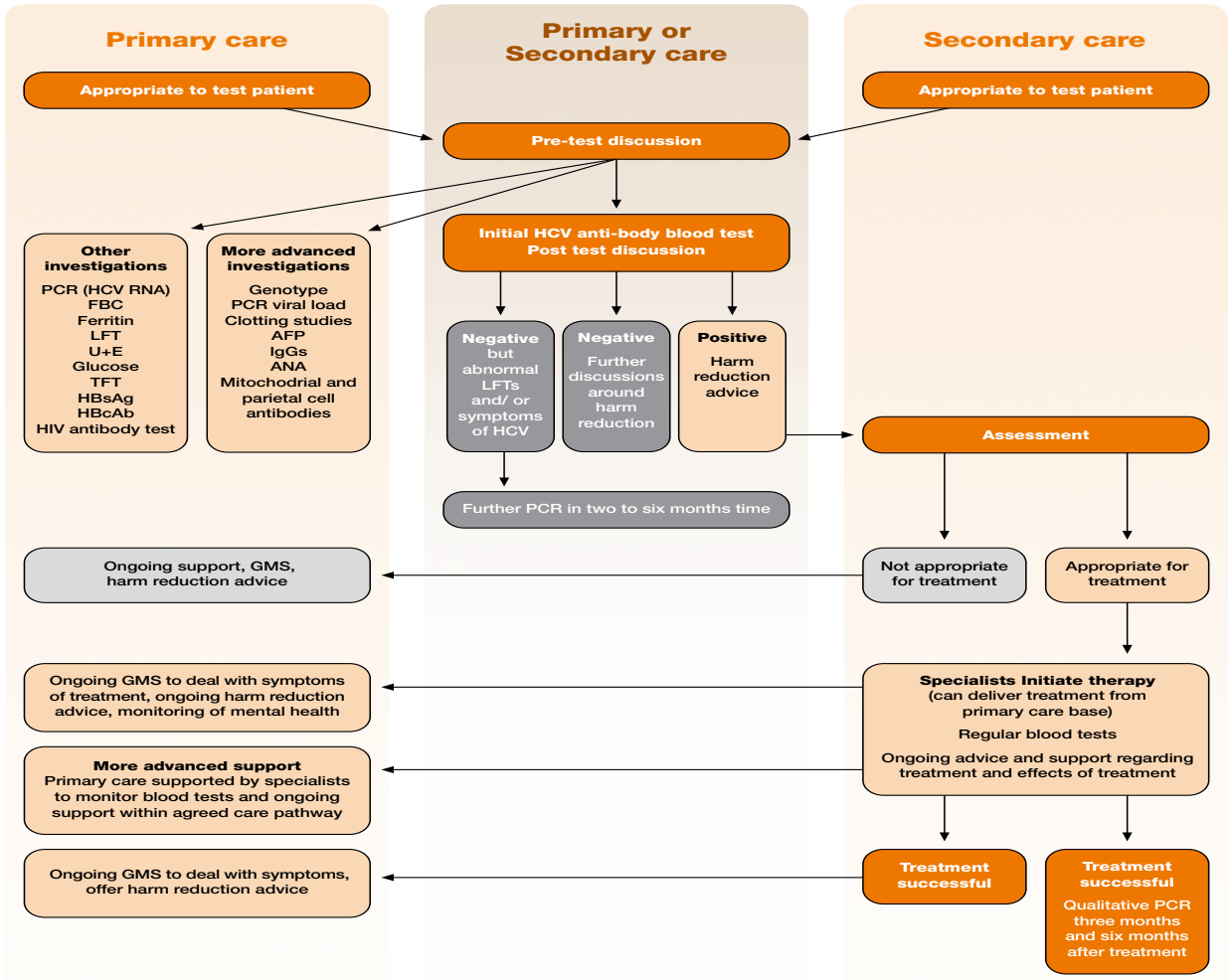
Vivienne Evans
Chief Executive Adfam,

25 Corsham Street, London, N1 6DR Tel: 020 7553 7640

Visit the Adfam website at
www.adfam.org.uk

...continued from front page

Testing and treatment care pathway in primary care



Executive Summary

INTRODUCTION

1. Hepatitis C infection is an under-diagnosed (5 out of every 6 people infected are undiagnosed) and under- treated important cause of morbidity and mortality
2. Hepatitis C is a common and potentially curable disease, but only 1-2% of infected people are currently receiving National Institute of Clinical Excellence (NICE) recommended therapy.
3. Every general practitioner is likely to have between 8 to 18 infected individuals per GP, (based on an average list size of 1800 and, partly depending upon local population demographics). Many of these patients may not be diagnosed and knowledge about HCV in population and primary care remains low but improving.
4. Prevalence of the hepatitis C virus (HCV) is estimated to be between 0.4 – 1% of the United Kingdom (UK) population, equating to be between 250,000 – 600,000 sufferers. Worldwide there are an estimated 170 million people, about 3% of the world's population, who are chronically infected with HCV
5. HCV is a blood-borne ribonucleic acid (RNA) virus that exists as a number of different strains (genotypes) and an important cause of liver disease. The effects of the infection vary from one individual to the next. Some people will remain symptom free, some will develop cirrhosis and others will develop liver failure or hepatocellular (or primary liver) cancer.

TRANSMISSION AND PREVENTION

1. Unlike hepatitis A and B, there is no vaccine but infection is avoidable through strategies that reduce transmission
2. Major route of transmission in the UK is sharing injecting equipment. Other risk factors include: blood transfusion (prior to 1991) or blood products (prior to 1987) and born or spent a significant amount of time in a high risk country. This may include health care given in early childhood so those born in the developing world may be at increased risk. A small but important number of infected people have acquired their infection through the use of non-sterile surgical equipment. This is most likely in those who have received health care in the developing world, including East Europe and Africa.

3. Practical suggestions to help prevention in primary care:

    1. *Provide hepatitis A and B vaccinations in all patients using drugs and other high risk groups such as men who have sex with men*
    2. *Provide clear information about safer injecting and safer sex including condoms*
    3. *Ensure that all patients using drugs have easy convenient access to local needle exchanges, which provide injecting paraphernalia as well as needles and syringes and advise about safer smoking of drugs*
    4. *Advise injectors of strategies how to move away from injecting*
    5. *Run a needle exchange in the surgery*
    6. *Discuss alcohol with all patients, advise to stop and treat or refer on any alcohol problem*
    7. *Provide drug treatment including substitute medication or refer to secondary agency for help*
    8. *Monitor weight and provide help with weight reduction (risk of non-alcoholic fatty liver disease which causes cirrhosis irrespective of any other causes and provide nutrition advice and support people who are HCV positive to optimize their nutrition*
    9. *Advice all patients to stop smoking and explain to people who are HCV positive that smoking can increase progression*

TESTING

1. As HCV is under diagnosed, testing in general practice is important, after ideally assessing all patients for risk factors – make no assumptions
2. Ensure the patient understands the condition and the test before taking blood for:

    a) HCV antibody blood test, to check if patient has been exposed to the hepatitis C virus

    b) HCV RNA (usually by a polymerase chain reaction (PCR), to check if infection active or not

DISEASE OUTCOME AND SYMPTOMS

1. Acute infection is usually asymptomatic but jaundice and malaise may occur. The incubation period of acute hepatitis C infection is usually between 6 and 9 weeks, with the specific antibody usually present by 3 months from infection, although in some cases it may take up to 6 months before antibody is detected. Most people who become infected with hepatitis C are unaware of it at the time. Around 25% of those infected with hepatitis C infection will clear the virus at the acute stage.
2. Chronic hepatitis C infection is a slowly progressive and often asymptomatic disease of the liver caused by the hepatitis C virus. Early studies in patients infected for up to 20 years indicated that the prevalence of cirrhosis was very low suggesting the disease progressed at a very slow rate. However recent studies suggest the disease does not progress in a linear fashion and that mild disease may accelerate with time so careful surveillance if important.
3. Many with chronic hepatitis C infection will have no symptoms, while others will feel unwell to varying degrees. Symptoms, though not common, may include mild to severe fatigue, muscle aches, nausea, depression or anxiety, pain or discomfort in the liver and poor memory or concentration .

TREATMENT

1. Early referral is advantageous. It is now thought that chronic HCV does not progress in a linear fashion and that the disease accelerates with aging so most patients with HCV may develop cirrhosis long term. Furthermore therapy is more effective when administered in the early stages of the disease and hence early referral is advisable
2. **The most recent NICE guidance advocates treatment for all that want it including:**

    a) active injectors

    b) for mild to moderate hepatitis C (previous NICE guidance was only for severe disease).
3. **The current treatment is combination therapy with pegylated Interferon and ribavirin.** This treatment is successful in clearing the virus (defined as no detectable virus) six months after treatment has ceased) in between 40-80% of those treated, accordingly to genotype.
4. **Where treatment is provided from a hospital base: primary care can continue to play an important role in the patient's treatment by providing ongoing General Medical Services (GMS)** to support the patient through the treatment process, supporting patients on therapy and giving practical advice to them on managing side- effects such as paracetamol for pyrexia, anti emetics if nauseated and moisturizers and steroid cream for itchy skin along with ongoing harm reduction information, support regarding drug dependency and monitoring of mental health, especially depression

This guidance is part of a series, which also includes the use of buprenorphine in opioid dependence treatment, treatment of cocaine users, hepatitis vaccination schedules, and methadone in opioid dependence treatment available online at

www.smmgp.org.uk and
www.rcgp.org.uk.

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Working with Substance Misusers

'Why it is the one aspect of my professional career that I enjoy the most.'

With the ups and downs of substance misuse work, why do we do it in the first place? We know it's much needed work, but Dr Nicolas Smith reminds us all why working with users and substance misuse is enjoyable and ultimately very rewarding. Ed

I am a doctor with a portfolio career, through which runs a common golden thread. I am a part time salaried GP in a Personal Medical Services, Primary Care Trust managed practice, serving a large council estate on the Wirral. I am an appointed Forensic Medical Examiner (FME) with the Wirral Division of Merseyside Police. I am a Clinical Assistant in Substance Misuse in the Criminal Justice Programme at Arch Initiatives in Birkenhead, and at the community based Wirral Drug Service.

Even as a young GP Trainee in the late 1980's, I found myself fascinated by the personalities and the needs of patients with substance misuse problems. Why you may ask, when so many of my colleagues at that time had an inherent mistrust and open dislike of people who are dependent on substances? The answer is really very simple. I share an addictive personality like many of the people with substance misuse problems and am able to empathise with them in so many ways. I am challenged by their individuality, different backgrounds and problems, aware that the common theme with all of them is the serious health and social problems relating to a lifestyle that often involves a relentless cycle of self-destructive, chaotic and dangerously addictive behaviour to one or more of the various substances, both legal and illegal, out there on the streets. I recognised then and more so now, that the vast majority of drug users genuinely need a lot of help and support and I as a GP, FME and Clinical Assistant am in the privileged position of being able to provide the best holistic care that I can to them, in all of the work that I do.

Don't get me wrong. I do not find it easy. I have had my fair share of negative experiences too. Early on in my career, I had my fingers burnt on a couple of notable and separate occasions with a couple of drug users who sadly took advantage of my early professional naivety. These incidents caused a powerful negative reaction in me towards drug users generally, because I felt deeply hurt by being taken advantage of. But I soon got over it. I wanted to. I needed to. The clinical needs of the clients made me.

Without any word of a lie, the most rewarding aspect of my professional career is definitely my role as a clinical assistant in substance misuse. Having attained the RCGP Certificate in Drug Misuse Part 2 so that I know the basic clinical skills, working with like-minded colleagues, substance misuse practitioners and even the police and the courts, who have recognised the importance of getting clients into treatment, is brilliant because by selling ourselves to our clients, we can help make a massive difference to their lives. It is fantastic to be involved in a process whereby a person whose health is seriously at risk can become stable, reduce their self-inflicted harm and turn around, look better, feel better, and be better! It is addictive in itself.

I encourage all of my colleagues to work with Drug Users, when they walk through our doors. Get trained and get some support services in place first. I hope you will find it as highly rewarding as I have and do as long as we all follow the guidelines, taking into account the person sitting before us and all of their complex needs. I thank all those with whom I work on both sides of the desk, and for their support and encouragement to me as one who could so easily have been the one asking for help.

Dr Nicholas Swift GP, FME, GPwSI at the Wirral Drug Service

Narcotics Anonymous - *demystified*

As we increasingly hear a more balanced debate on treatment and recovery approaches for individuals, NA and abstinence quite rightly feature as available options. NA is established globally and is recognized by many as a powerful recovery process and support network. It may not be for all, and some struggle understanding the approach. So NA provide us with a very useful and clear outline of the organization, its traditions and insight into its philosophy and workings. No doubt an organization that more clinicians could do well to recognise. Certainly for many it provides a life changing and powerful opportunity for recovery. Ed.

Narcotics Anonymous is an international, community-based association of recovering drug addicts with more than 44,000 weekly meetings in over 125 countries worldwide. NA sprang from the Alcoholics Anonymous Program of the late 1940s, with meetings first emerging in the Los Angeles area of California, USA, in the early 1950s. Today, Narcotics Anonymous is well established throughout much of the Americas, Western Europe, Australia, and New Zealand, with growth throughout the Indian subcontinent, Africa, East Asia, the Middle East, and Eastern Europe. NA books and information pamphlets are currently available in 65 languages. All ethnic and religious backgrounds are represented among NA members: once a national movement reaches a certain level of maturity, its membership generally reflects the diversity or homogeneity of the background culture.

Program

NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. Membership is open to all drug addicts, regardless of the particular drug or combination of drugs used. There are no social, religious, economic, racial, ethnic, national, gender, or class-status membership restrictions. There are no fees or dues for joining; in fact the only requirement for membership of NA is a desire to stop using.

NA members are encouraged to comply with complete abstinence from all drugs, including alcohol. It has been the experience of NA members that complete and continuous abstinence provides the best foundation for recovery and personal growth.

Narcotics Anonymous provides a recovery process and support network inextricably linked together. One of the keys to NA's success is the therapeutic value of addicts working with other addicts. Members share their successes and challenges in overcoming active addiction and living drug-free productive lives through the application of the principles contained within the Twelve Steps and Twelve Traditions of NA. These principles are the core of the Narcotics Anonymous recovery program. Principles incorporated within the steps include:

- admitting there is a problem
- seeking help
- engaging in a thorough self-examination
- confidential self-disclosure
- making amends for harm done
- helping other drug addicts who want to recover

The Twelve Steps form both a structured process for recovery from active addiction, and also a practical toolkit for the daily living of life on life's terms, helping members to become responsible and productive members of society.

Central to the Narcotics Anonymous program is its emphasis on practicing spiritual principles. Narcotics Anonymous itself is non-religious, and each member is encouraged to cultivate an individual understanding—religious or not—of this "spiritual awakening."

Some of NA's Traditions

Narcotics Anonymous is not affiliated with other organizations, including other twelve step programs, treatment centers, or correctional facilities. As an organization, NA does not employ professional counselors or therapists nor does it provide residential facilities or clinics. Additionally, the fellowship does not provide vocational, legal, financial, psychiatric, or medical services. NA has only one mission: to provide an environment in which addicts can help one another stop using drugs and find a new way to live.

In order to maintain its focus, Narcotics Anonymous has established a tradition of non-endorsement and does not take positions on anything outside its own specific sphere of activity, from addiction-related issues such as criminality, law enforcement, drug legalisation or penalties to wider social, political or religious issues.

Narcotics Anonymous is entirely self-supporting and does not accept financial contributions from non-members. Based on the same principle, groups and service committees are run by NA members, for members.

Service organisation and cooperation

The primary service provided by Narcotics Anonymous is the NA group meeting. Each group runs itself based on principles common to the entire organisation, which are spelled out in NA's literature. Most groups rent space for their weekly meetings in buildings run by public, religious, or civic organisations. Individual members lead the NA meetings while other members take part by sharing in turn about their experiences in recovering from drug addition. Group members also share the activities associated with running a meeting.

In places where a number of Narcotics Anonymous groups have had the chance to develop and stabilise, groups will have elected delegates to form service committees to manage activities such as: distribution of NA literature; telephone information services; public information presentations for treatment staff, civic organisations, government agencies, and schools; panel presentations to acquaint treatment or correctional facility residents with the NA program; and meeting directories for individual information and use in scheduling visits by client groups.

Although certain traditions guide its relations with other organisations, Narcotics Anonymous welcomes the cooperation of those in government, the clergy, the helping professions, and private voluntary organisations. NA strives to cooperate with others interested in Narcotics Anonymous by providing contact information, literature, and information about recovery through the NA Fellowship. Additionally, NA members are often available to make panel presentations in treatment centers and correctional facilities, sharing the NA program with addicts otherwise unable to attend community-based meetings.

UK Public Information Subcommittee, Narcotics Anonymous
Tel: 020 7251 4007.
Email: pi@ukna.org.

Dr Fixit on Over-the-counter medication

Dear Dr Fixit

I wonder if I could ask for some help with a patient of mine? Sue first presented a couple of months ago with abdominal pain. On examination she had gastritis and on discussion she informed me that she was taking about 40 Nurofen Plus ™ per day. She had started using them after she had a series of headaches caused by a particularly stressful time at work. Sue had found that they relieved the headaches and improved her mood. She had started taking about 4-6 / day but found that she needed to take more to get the same effect and was now regularly taking 40 / day. I had no experience of treating this type of problem so I referred her to our local drug service, who were very unhelpful and only offered supervised methadone. She returned to see me the other day asking for help. She had never been in drug treatment and had not liked the experience. She had tried to stop using them by herself but had found it impossible and her gastritis was getting worse, even after I had prescribed omeprazole. I am willing to try to help but I am not sure how - can you help me?

Answer by Dr Chris Ford & SMMGP Clinical Lead

Thanks for your query and I hope I shall be able to help. At the surgery we have now had six patients with 'over the counter dependency' problems, over the past year, so we have gained a little experience through trial and error. Four had had previous dependency problems but two had not.

As I am sure you know Nurofen Plus™ is a compound analgesic available over the counter containing 200mg ibuprofen and 12.8mg codeine per tablet. Most of our patients, like Sue have presented with the physical effects from taking the ibuprofen, the element of the drug not wanted and the dependence is on the codeine element. So Sue is taking 8000mg or 8grams of ibuprofen in order to obtain 512mg of codeine. Codeine phosphate, a weak opioid drug, is only available on prescription but has been available over-the-counter in combination with aspirin and paracetamol containing up to 8mg codeine per tablet and up to 12.8mg when in combination with ibuprofen.

The extent of dependence on non-prescription drugs has been estimated to affect more than 30,000 people in the UK. Addiction to codeine included in painkillers has been recognised for many years but anecdotal reports suggest it is increasing –this would clearly seem like an area needing research to assess and monitor the extent of the problem. There is a little information about this in pharmacy magazines but very little research into addiction to over the counter drug dependence in the UK. There are however numerous websites and media articles documenting cases of addiction and offering support to those people trying to withdraw from these drugs. Websites such as over-count.org.uk and codeinefree.me.uk tell many personal stories, often remarkably similar to Sue's and usually starting with appropriate use of analgesia for pain such as back injury or menstrual cramps. Over-count reports that many people require additional medication, such as ranitidine, to treat dyspeptic symptoms. They also report the most commonly reported addiction to be to Solpadeine (500mg paracetamol and 8mg codeine).

When treating our patients we have offered a choice of medication and talking therapies. All have wanted a detoxification regime. The choice of medication we offer is a reducing dose of codeine phosphate, lofexidine or dihydrocodeine and all have accessed, to varying degrees CBT. Two patients have gained additional support from the 12 step programme. We need to get Sue off the ibuprofen as soon as possible and as she does not have a previous opioid problem and is taking 40 tablets / day I would suggest trying codeine as first choice. I base this on experience rather than evidence, perhaps using lofexidine when the dose is low. The starting dose of either codeine or dihydrocodeine has to be patient dependent and using the tried and tested method of titrating withdrawal symptoms against dose. With Sue I would start on 30mgx3 tablets of codeine phosphate qds. It's important she divides the dose to avoid peaks and troughs. From there you may need to increase her dose or if she settles on this dose then you can begin the reduction. Again reduce at her speed, but see her frequently and adjust the dose as necessary. If you or she choose dihydrocodeine I would use a similar regime, if lofexidine I would use your standard regime leaving her on maximum dose for 5-7 days before reducing.

Let me know how you get on

Dr Fixit on hepatitis C treatment

Dear Dr Fixit

Alan has been a patient of mine for the last 6 months. He has known he is hepatitis C positive for 8 years and had a liver biopsy 4 years ago which showed no fibrosis so he was not offered treatment.

He has stabilised well on 90mg of methadone mixture but he continues to inject crack, about twice / week, or more frequently if he has funds. He did drink about 10-20 units of alcohol / week with occasional binges but with support has stopped all alcohol. He does smoke about 20 cigarettes / day.

On a recent visit he complained of feeling unwell and tired and it was beginning to affect his work as a painter and decorater. I took some bloods and the results show he is hepatitis C antibody positive, immune to hepatitis A and B and HIV negative. His HCV is active (pcr positive) and he is genotype 1. His LFTs are normal except a slightly raised ALT.

Alan has accepted my suggestion of a referral to the local hepatology unit but what can I tell him about what is likely to happen there? What further investigations are you likely to do and will he need another liver biopsy? Also will he be offered treatment because he is continuing to inject and if yes what would he be offered and for how long? Is there much I can tell him about success rates, especially as he is genotype 1?

Answer by Graham Foster
Consultant Hepatologist, London

Alan will be assessed by one of the hepatologists and his baseline liver status re-assessed with a full blood count, liver function tests and an ultrasound. The advice that he has already received about the importance of preventing onward transmission whilst injecting and the value of continuing to abstain from alcohol will be re-iterated.

Alan will be offered choices regarding his future management. The choices are to have a course of therapy with pegylated interferon and ribavirin, defer therapy until more effective therapies are available or have a liver biopsy to assess the progression of his liver disease and then chose whether to undergo treatment or commence watchful waiting. The advantages of early therapy are that it may remove the stigma of infection and it is most likely to be effective in early HCV in young people. The disadvantages are that it may interfere with Alan's work (he may need to take some time off work if he is one of the 20% of patients who develop severe side effects) and early therapy can not, obviously, involve some of the new experimental drugs that are currently in development. These may offer Alan a better chance of a sustained response in five to ten years time. Alan's own views are of critical importance here as each patient has a very different view of the advantages/disadvantages of early therapy. Alan will be given an opportunity to consider his choices and may, if he so wishes, discuss the side effects of therapy with one of the hepatitis nurse specialists. Most experts will allow a young man with early hepatitis C to make an 'uninfluenced choice' but if there is any evidence of progressive disease (i.e. a falling platelet count or abnormalities on the liver ultrasound) then most clinicians would try and persuade Alan either to undergo therapy or to repeat the liver biopsy to confirm that he has not entered the progressive phase of the disease.

If Alan chooses to defer therapy he will be reviewed once or twice a year to update him on recent developments in hepatitis C therapeutic options. If he decides to start treatment then arrangements will be made for this to take place. Starting therapy is not contingent upon a further liver biopsy but if Alan wants to make his decision regarding therapy on the extent of his liver fibrosis then a liver biopsy will be necessary.

If Alan does chose to start treatment he will probably be reviewed by a psychiatrist to confirm that he is psychologically stable and to provide a baseline assessment prior to commencing therapy. His on-going drug use will be discussed and monitored during treatment but active drug use is not normally considered an absolute contraindication to therapy and Alan's own views on treatment and his personal motivation are more important than his recreational habits. Since he has genotype 1 infection, Alan will need 48 weeks treatment but his response will be assessed after 4 weeks and 12 weeks – if he is responding really well, therapy may be stopped after 24 weeks but if he is responding poorly treatment may be abandoned after 12 weeks. Alan should expect to be seen every week for the first few weeks of therapy and then monthly for the duration of therapy. Alan has no more than a 10% chance of being a 'super responder' who only needs 24 weeks treatment and he has around a 15% chance of being a '12 week non-responder' in whom therapy will be withdrawn as futile after 12 weeks. Overall Alan has about a 50% chance of responding to treatment.

BULLETIN BOARD

SMMGP: 2nd National Conference "Bringing it Together" Effective Primary Care Based Drug Treatment Services 07 & Beyond

Friday 21 September 2007, 9.30am-4.30pm at the Burlington Hotel, Birmingham, details www.smmgp.org.uk courses and events section

Performance & Image Enhancing Drugs in the 21st Century

Friday 5 October 2007 at the Liverpool Marriot City Centre Hotel Details from http://pied-conference.net

SMMGP/RCGP/NTA 2nd West Midlands Annual Conference.
Harm Reduction and Drug Treatment

Venue Governement Office for the West Midlands, Birmingham 19th October

To Include: Hepatitis Treatment, Safer Injecting, Sexual Health, Alcohol and Harm Reduction. The event will include presentations and workshops

Keynote speaker: Dr GrahamFoster, Professor of hepatology, London Hospital.

For more information please contact patricia.wright@nta-nhs.org.uk

National RCGP Certificate in the Management of Drug Misuse – Part One

14th November 2007 RCGP, 14 Princes Gate London

To reserve a place please contact Jo Betterton jo.betterton@rcgp.org.uk

RCGP stand alone CPD events:

Update on Dual Diagnosis Tuesday 18th September; RCGP HQ, Princes Gate, Hyde Park London

Update on screening and brief interventions for alcohol Monday 8th October; RCGP, Princes Gate

Update on prescribing for Opiate users Tuesday 23rd October; RCGP Princes Gate

For information on booking these events please contact Jo Betterton at the Substance Misuse Unit (SMU) on jbetterton@rcgp.org.uk

Drug misuse and dependence – guidelines on clinical management: update 2007 CONSULTATION (11 JUNE – 31 AUGUST 2007)

In 2006, the UK health departments asked the National Treatment Agency for Substance Misuse (NTA) to set up an independent expert working group to update 'Drug misuse and dependence - guidelines on clinical management', last published in 1999.

The results of this work in developing an update have now been published for public consultation and you are invited to comment on the consultation draft. Comments MUST be made on the attached proforma (also downloadable from the NTA's website at www.nta.nhs.uk), which should be returned to the NTA at the consultation email address: clinical.guidelines@nta-nhs.org.uk. Since much of the consultation period falls over the summer, I would encourage you to send in your comments as early as possible and preferably before 27 July 2007 (the formal deadline for responses is 31 August).

NETWORK Production

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NETWORK NEWSLETTER
IS SPONSORED BY
SCHERING-PLOUGH LTD
Network ISSN 1476-6302

SMMGP works in partnership with

National Treatment Agency for Substance Misuse